Editorial

Attitudes Toward Error Disclosure Need to Engage with Systems Thinking

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Error disclosure involves initiating open discussions about clinical incidents. In cases where incidents lead to harm (which may or may not be attributable to an error), their disclosure engages the people to whom the incident matters most—the patient, the family, the clinicians involved in the incident, and staff who carry general responsibility for the service. In these conversations, the participants talk about the technical aspects of what went wrong, as well as about their personal experiences and needs. That is why disclosure of incidents harbors an unusual energy: everyone will be seeking what they regard as satisfactory closure. Clinicians, patients, family members, and support staff alike will want to know what they and others could have done differently, what difference such hypothetical actions might have made to what happened, and what they need to do in the future to prevent similar incidents from happening again.

Disclosure of incidents involving patient harm is complex, especially if an error was made. Errors are complex not just with respect to what happened but because they complicate the patient's trust in his or her care and in the clinicians who provide it. The fiduciary basis on which the patient agrees to be treated extends across the entire range of care, including all professionals and services contributing to the treatment. This trust cannot be reduced to the physician-patient relationship. Researchers acknowledge this when they describe clinical care as "a complex sociotechnical system."[1] Derived from systems thinking,[2] this terminology tells us that care providers at the bedside are enabled in what they do by a whole array of professionals, support staff, information and medical technologies, administrative arrangements, and organizational facilities. Patients' trust does not stop with those present on the hospital ward but extends across the whole network of care.

As much as care is not reducible to what frontline clinicians do and say, incidents of patient harm cannot be gauged by the actions of the last physician or nurse to attend to the patient. Incidents may implicate those who contribute to structuring the care of the patient and the service generally. True, professionals' sense of responsibility for specific incidents may be deeply personal, whereas others may regard their responsibility as more formal and governed by their official function. Be that as it may, responsibility for an incident does not taper off the further away a professional is from the patient. Safety science has shown that incidents may result from an accumulation of problems and actions that originate at considerable distance from the patient.[3]

Risk managers work at one or more removes from frontline care. Focusing on service quality, safety, and recovery, they occupy an important position in the handling of incidents. They assist clinicians and patients in resolving incidents, and they guard the service against undue risk. For their part, physicians provide frontline care and may therefore be "directly" implicated in incidents. These different roles, functions, and experiences need to be reconciled when risk managers and physicians team up to disclose incidents to patients and their families.

The Loren et al. article in this issue of the *Journal* sheds important light on the challenges that practitioners face in disclosure.[4] The article illuminates the differences between risk managers' and physicians' stances on disclosure and apology. Risk managers are more inclined than are physicians to disclose and analyze an error, whereas they are less inclined to apologize for it. Physicians are less inclined to use the term *error*. The authors conclude that the disclosure process may produce interprofessional tensions and that "collaboration between risk managers and physicians could take advantage of both parties' respective strengths and lead to disclosures that better meet patient expectations."[4(pp. 106–107)]

The Loren et al. finding that risk managers generally approve of disclosure suggests that their attitudes toward managing risk have shifted. This makes them, as the authors note, important advocates for disclosure as an effective way of managing organizational risk. By the same token, the finding reminds us of a distinction between the technical (measurable) and the relational (personal) dimensions of safety.[5] Loren et al.'s analysis locates risk managers' views of error within a framework of investigation and improvement. Risk managers may be

less inclined to apologize precisely because they regard themselves as occupying a technical, problem-solving function. In regarding their work as too removed from patient care to warrant offering apologies to those harmed, they frame apologizing as contingent on personal proximity to the patient, not institutional responsibility for the service provided.

Safety science tells us that proximity is but one among a range of factors that inform how we determine the sources and causes of harm. Acts of omission and commission enacted in the manager's office may contribute to incidents as much as (and sometimes more than) acts on the ward. For their part, physicians are concerned with the personal dimensions of disclosure. They are sensitive to the negative impact on their patients' and colleagues' perceptions of using the word *error*, of disclosing an error, and of offering an apology as a way of recuperating confidence in their skills and intentions. As it did for the risk managers, proximity to the patient governs how physicians frame their relationship to the incident and to those harmed. Neither professional group construes its role in the incident from the perspective of the service institution as interconnected system.

Systems thinking is what underpins not just safety science but also "just culture."[6] Systems thinking treats individual clinicians, professional groups, and care practices as interlinked. Without downplaying the significance of personal contact for how roles and tasks are enacted, systems thinking acknowledges that professional relationships, clinical processes, and health organizational arrangements are interdependent. This interdependence distributes responsibility for outcomes and errors, suggesting that incidents are not explainable on the basis of a single factor such as patient proximity. In this regard, the Loren et al. article raises a critical question over and above its identification of potential tensions around disclosure between risk managers and physicians: If and when an error occurs, do clinical professionals privilege patient proximity as the sole factor that determines their approach to disclosure, use of disclosure terminology, and decision to offer an apology? If they do, as the article suggests, then professional attitudes toward disclosure communication—although encouraging in other respects—remain out of alignment with health care organizational learning about safety and systems thinking.

Physicians, who are "closer to the incident," see themselves as more personally responsible, more concerned about disclosure, and more in need of apologizing to those harmed than professionals at one or more removes from the incident.[7] In doing so, they may weaken the ground on which we have sought to erect a more sophisticated and just approach to dealing with incidents, disclosure, and blame—an approach that emphasizes the complex systems characteristics of care.[8] Risk managers, who are "further from the incident," may regard themselves as less personally implicated and therefore more able to be proactive about disclosure and incident investigation—and less in need of apologizing than those closer to the incident. However, their stance also dilutes the principal function of their current role—to eschew simplistic assumptions about incident causality, service responsibility, and error disclosure.[9] The article thereby intimates that both professional groups have yet to claim ownership over the main components of health care reform and patient safety: systems thinking and just culture. J

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